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The Role of the Health Department in the Prevention of Prematurity

An exploration of what health departments can do to prevent premature births was made at two working conferences in Northern and Southern California during May. Probably the first attempt anywhere to identify the prevention of prematurity as an entity in the public health program for maternal health, the conferences were unique in another respect since participants included all of the professional disciplines that have an important contribution to make to the solution of this major public health problem.

Sixty-four percent of all neonatal deaths in California are among prematures, according to a study made of 1949 data. Prematurity is eighth in the leading causes of death for all age groups.

Sponsorship of the conferences was by the Bureau of Maternal and Child Health of the State Department of Public Health and the Maternal and Child Health Committee of the Conference of Local Health Officers. Six other administrative units in the state department were co-sponsors.

Approximately 150 persons participated in each of the two regional three-day meetings. The majority of them were administrators and staff of local and state public health departments, but there were also representatives of university faculties in medicine, public health, nursing and nutrition; private medical practice; public and private hospitals; medical and hospital insurance plans; and public welfare and school departments. The professional disciplines represented included the medical specialties of public health, obstetrics, pediatrics, general practice, hospital administration, nursing, nutrition, education, social work and statistics.

Papers were presented on "Prematurity and its Relationship to Maternal Health" by Dr. Nicholson J. Eastman, Professor of Obstetrics, Johns Hopkins University, and on "New Educational Concepts and Their Implications for the Prevention of Prematurity" by Dr. Dorothy B. Nyswander, Professor of Health Education, University of California. It is planned to publish them in subsequent issues of *California's Health* and to publish digests of panel discussions on "Obstacles in Preventing Prematurity" and "Ways to Determine and Meet Maternal Needs."

Summarized here are the findings of 18 working groups, each consisting of approximately 15 persons from various professional fields. The general purpose of the conferences was to consider: (a) the responsibility of the health department in the prevention of prematurity; and, (b) the public health methods which can be used effectively to prevent prematurity. Three questions related to this objective were posed to each of the 18 working groups. No attempt was made at the conferences to obtain general agreement on the group recommendations; rather the findings are in the nature of a general exploration and the recommendations are suggestive for further consideration and action by appropriate local and state agencies and individuals. Although the 18 groups were divided into three sections according to three hypothetical health department jurisdictions with differing characteristics, the findings of all groups were essentially similar; consequently, a consolidated report is presented here.

BASIC CONSIDERATIONS

A few points were mentioned so frequently by the working groups and in general discussion that they may be considered basic to consideration of any of the findings and recommendations. They are:

1. While knowledge of the causes of premature birth is incomplete, application of what we do know can reduce the incidence. (One group dissented and recommended further study.)

2. Epidemiologic methods are suited to a program for the prevention of prematurity.
3. The problem is of public health significance and the health department has leadership responsibility in the program. What the health department does will be determined by local needs and resources and the kind of community program undertaken.
4. Participation, starting with early planning stages, of all agencies and groups which can contribute to the program is essential. Foremost among them are practicing physicians and hospitals. Participation of legislative bodies, expectant parents, and the public should not be overlooked in the planning and development of services.
5. It is important that all professional disciplines that have any responsibility in preventing prematurity should work together on a continuing dynamic basis.

DETERMINING NEEDS AND MEASURING PROGRESS

The first question asked of the working groups was, "What can the health department do to determine needs and measure progress as related to the prevention of prematurity?" Their thinking is summarized below.

1. *Analyze Existing Data and Make It Available*

The health department has data which, if analyzed and brought to the attention of practicing physicians, hospitals, and other agencies, as well as to the attention of health department staff, would be helpful in determining needs and establishing a baseline for the measurement of progress. Much of this information is contained on the records of live births, stillbirths, and deaths. Other health department records which will reveal helpful clues are records of antepartum and postpartum nursing visits, family case records, and crippled children's service records. The notations of physicians on birth records of the period of gestation at which prenatal tests for syphilis were made is one measure of the extent to which women in the community are obtaining medical care early in pregnancy.

Other data exist which need to be collected and made available. Included are statistical data collected by the State Department of Public Health, information on local hospital records and the records of any agency which is providing services to pregnant women.

2. *Stimulate the Collection of Better Data*

Information on birth certificates frequently is incomplete, particularly regarding a diagnosis of syphilis and complications of pregnancy or labor. Health departments could effect an improvement by making it generally known that medical and health data are no longer included as part of the public record sent to county recorders or on certified copies, except for special purposes which are specifically authorized.

The health department can interest other local agencies in the collection of additional data which will throw light on the problem. For example, a group reported that one of its members—the administrator of a large county hospital—planned to have clerks obtain information from maternity patients on the prenatal care they had received. This would be done at the time the clerks secured data for birth certificates.

Participation by other groups in using the data will, of itself, stimulate collecting of better data.

3. *Investigate the Adequacy of Community Services*

The health department should participate with the medical society, hospitals, and other community agencies in a study of community resources and needs in maternal health services. Such a study would define the local problem and supply a basis for community planning and action. Data collected might include the following:

The local incidence of prematurity and groups most affected—private or public hospital cases, occupational and racial groups, etc.

Maternity services available and the extent to which they are used.

Barriers which make it difficult or prevent some women from receiving prenatal care.

Cultural patterns which influence the kind of maternity services sought and received.

EDUCATION FOR THE PREVENTION OF PREMATURITY

Summarized below are the reports of the working groups on the question, "What can the health department do to promote an education program directed to the prevention of prematurity?"

1. *Conduct and Encourage Inservice Professional Education*

Health department staffs need to know more about prematurity and their role in prevention. A start could be made by holding staff meetings as a follow-up on the state conferences and, particularly in large departments, by opening channels to inform staff of the local problem and of administrative planning.

A local working conference on the prevention of prematurity for professional groups in the community would be one way to start local inservice education.

The health department and the medical society might interest physicians in holding case conferences on premature births and fetal deaths. In populous areas, the studies could be conducted by hospital staffs; in some rural communities the number would be so small that a committee could review all cases occurring in the county.

The health department can assist in the inservice education of staff of other agencies who have important

contributions to make in the prevention of premature births. This will include the staffs of school departments, agricultural extension, hospitals, and social agencies.

Participation by health department staff, the medical society and community agencies in a study of local needs and in the planning of program development is an effective method of inservice professional education.

2. Conduct Public Education

The health department has a primary responsibility for the education of the public in matters of health and has many opportunities to reach people through its community-wide educational program and through established health department services, such as in clinics, parents classes and during home nursing visits.

An effective way to educate women to take advantage of services is to have the kind of service which provides a satisfying experience for them; if this is done they will avail themselves of the service and will educate others.

If teaching is to be acceptable, and thus lead to positive action, there is need for it to be planned with the people who are to be the recipients. Natural leaders among the groups to be reached should be found and utilized.

There is particular need for better education of children in responsible parenthood and family living which will influence their attitudes and health practices when they become expectant parents. Education in this field should be a part of the curriculum at all grade levels for both sexes. The health department can assist schools to strengthen their health teaching and to gain community acceptance of classes in family life education.

PRENATAL SERVICES

The final question asked the working groups was, "What can the health department do to extend and improve prenatal services which will help to reduce the incidence of prematurity?" Their reports are summarized below.

1. Give Community Leadership

The health department has responsibility for seeing that good prenatal care is readily available to all expectant mothers but not, necessarily, for providing prenatal care. Important elements of readily available good prenatal care are services, with continuity, in a location and at a time convenient to the patients, given by competent staff who have the ability to listen. Expectant mothers should not be required to sit for long periods of time on hard benches while they wait their turns to see the physician and there should be no artificial barriers to eligibility, such as residence requirements.

The decision as to what needs to be done locally should be made locally with full participation by the practicing physicians. A continuing advisory committee of the medical society is recommended.

Depending upon present community services, the provision of readily available good prenatal care for all pregnant women may include one or more of the following actions:

Modification of clinic eligibility restrictions.
Decentralization of clinics, possibly through the use of mobile units.
Establishment of new clinics.
Establishment of prenatal nursing conferences and expansion of antepartum home nursing visits.
Provision for the hospitalization of nonresident medically indigent patients who have complications of pregnancy.
Extension of prepayment insurance coverage.
Establishment of a system for interagency referral.
Provision of home making services.

In communities with limited medical, hospital and public health resources it may not be possible to provide adequate prenatal care for all pregnant women early in pregnancy. In such instances special emphasis should be placed on priority groups—those thought to be most susceptible to premature labor, such as primiparas, those with previous losses or complications, the nonwhites, and those in the low socio-economic group.

2. Fill the Gaps

Although health departments do not necessarily have responsibility for providing prenatal care they should give public health services which are needed and which cannot be assumed by private practice, hospitals or some other community agency. Depending upon the local situation, these services might include public and professional education, analysis of data, parents classes, home visits by public health nurses including visits to patients of private physicians, and prenatal clinics.

Health department clinics should be operated with the guidance of obstetricians and in close cooperation with the county hospital to assure continuity of care during the maternity cycle. It is suggested that in some areas it might be advisable to consider the operation of prenatal clinics in conjunction with other health department clinics to constitute a family service rather than a series of specialized services.

The importance of postpartum services in the prevention of prematurity should not be overlooked when antepartum services are expanded. The time immediately following a premature birth or fetal death is the time to start to prevent a recurrence.

Health departments which decide to undertake additional prenatal services will need to evaluate their

present programs and place priorities so that necessary staff time can be released.

RECOMMENDED ACTION FOR STATE ORGANIZATIONS

Nearly all groups pointed out how they felt the State Department of Public Health and other state organizations could help local health departments and community groups develop more adequate services directed toward the prevention of prematurity.

1. Studies

Conference of Local Health Officers. It was recommended that the conference might study county hospital policies and legal restrictions on admission of pregnant women for outpatient and inpatient care and make recommendations to the County Supervisors Association.

Another recommendation was that, in cooperation with other professional groups, the conference might study and develop standards for prenatal care for the guidance of health departments and other community agencies.

State Department of Public Health. The state department was asked to explore with other appropriate agencies, such as schools of medicine and public health, the feasibility of initiating research in the prevention of prematurity. Other working groups reported the need for studies in the following fields:

a. A study to determine if there is a difference in the physical, emotional and social factors present in pregnancies which terminate prematurely as compared with those which go to term. One group recommended that such a study be made on a current, continuous basis, and two other groups recommended retroactive studies.
b. A demonstration study to develop effective ways of providing services for the prevention of prematurity in a rural area removed from medical centers where there are few local resources and facilities and there are problems of distance and transportation.
c. A study of the nutritional habits of women who have had premature babies.
d. A study of the prenatal care of women in industry.
e. An administrative study of ways small health jurisdictions can share the services of the medical social worker, nutritionist, health educator and record analyst.

2. Professional Education

The Conference of Local Health Officers was asked to consider through its liaison committee with the California Medical Association, the need for placing special emphasis on postgraduate education in prenatal and obstetrical care and their relation to premature birth.

Medical Schools. It was suggested that medical school curricula might include courses which would assist the student in becoming aware of his responsibility in community problems, such as the prevention of prematurity, and that postgraduate courses in obstetrics and obstetric consultation services should be offered to general practitioners.

The State Department of Public Health was asked to supply continuing information on research and program development. It was suggested that the state department could also be helpful in inservice education of staff and in assisting local departments in community organization for study and action in the prevention of prematurity.

3. Records

The State Department of Public Health was asked to consider the following changes in the birth certificate form:

a. Add an item to obtain information regarding previous premature deliveries and another asking for the length of the baby;
b. Substitute for the item asking for the number of weeks of gestation one asking for the date of the last known menstruation;
c. Provide a checklist of the complications of pregnancy.

It was suggested that the Division of Laboratories and the Bureaus of Maternal and Child Health and Venereal Diseases might explore the practicality of having included on the prenatal blood test laboratory form a notation as to the period of gestation so that local departments might have this information as a guide for follow-up on prenatal care.

4. Committees

The State Department of Public Health. It was recommended that a standing advisory committee to the state department on the prevention of prematurity be appointed with representation from the California Medical Association, the specialty societies in obstetrics and gynecology and from medical schools.

The department was also asked to appoint a follow-up committee to assess the influence of the working conferences and to consider calling other meetings on this problem at a later date.

Conference, Medical Association, State Department. Another recommendation was made for the appointment of a State Committee on the Prevention of Prematurity with representation of the California Conference of Local Health Officers, California Medical Association and State Department of Public Health. It was suggested that in each local public health jurisdiction a committee also be appointed with wide representation which might make recommendations on general and specific needs to the state committee.

Los Angeles to Play Host in 1953 to Western Branch, A.P.H.A.

Host city for the 20th Annual Meeting of the Western Branch, American Public Health Association, will be Los Angeles and the dates are set for June 10 through 13, 1953; place, the Biltmore Hotel. This was the decision of the regional board at the recent 19th Annual Meeting of the Western Branch June 4th-6th in Denver. The board also accepted the invitation of Seattle to meet there in 1954.

The host city can also claim the new president of Western Branch—Dr. L. S. Goerke, Director of the Bureau of Medical Services, Los Angeles City Health Department, who succeeds Mr. L. J. Peterson, Idaho State Director of Public Health.

Other officers elected for the ensuing year include President-elect Curtiss M. Everts, Jr., Oregon State Board of Health; Vice President Leland E. Powers, M.D., University of Washington, Seattle; Vice President G. D. Carlyle Thompson, M.D., Montana State Board of Health, Helena; Vice President Ellarene MacCoy, M.D., California State Department of Education, Los Angeles; and Secretary-Treasurer Mrs. L. Amy Darter, Supervising Bacteriologist, Division of Laboratories, California State Department of Public Health, Berkeley.

Mr. Harold Gray, who has served as secretary-treasurer of Western Branch for several years, was selected as editor of Western Public Health, official publication of Western Branch.

Two Californians were elected to the regional board —Miss Gloria Russo, Director of Health Education, Orange County Health Department; and Mrs. Fannie T. Warncke, Director of Public Health Nursing, Oakland City Health Department.

Dr. Wilton L. Halverson, California State Director of Public Health and President-elect of A.P.H.A., gave the keynote address on "Public Health Services for Western America."

Dr. Florence Sabin, Chairman of the Board of Health and Hospitals, Denver, presented the annual John T. Sippy Memorial Lecture. Her topic was "Trends in Public Health." It is planned that these and other papers given at the Denver meeting will be published in *California's Health* in early issues.

Sanitarian Position, Imperial

There is a vacancy for a sanitarian in Imperial County Health Department, at $325-$350 per month, depending upon qualifications and experience. Car furnished for official use only. Write Thos. E. Patton, M.D., Health Officer, 1007 Hamilton Ave., El Centro.

Conference of Local Health Officers Hears Dr. Haven Emerson

At the recent semiannual meeting of the California Conference of Local Health Officers in Los Angeles Dr. Haven Emerson, Past President of the A.P.H.A., Professor Emeritus of Public Health at Columbia University, and presently Consultant on the Accreditation of Field Training Areas, spoke on the topic of residency training for public health physicians. Dr. Emerson discussed the present training program which leads to certification of public health physicians by the American Board of Preventive Medicine and Public Health. Two local health departments in California—Alameda County and the San Joaquin Local Health District—are presently approved for such residency training.

Also addressing the conference, Dr. Wilton L. Halverson, State Director of Public Health, stressed the importance of the technical assistance the United States is giving in some of the underdeveloped areas of the world. He pointed out that local and state health departments in this Country must do all they can to help our government further this work, including the possible release of personnel for short-term loan to other countries. Dr. Halverson and a team of public health workers recently completed a survey of the health activities of the Institute of Inter-American Affairs in South America.

From the business sessions of the conference a number of recommendations were adopted, including the following:

1. *Health Center Construction*

The conference recommended that the Hospital Advisory Council continue to approve allocations for health center construction consistent with the acute need for them.

It was also recommended that the square footage allotment for health centers be increased to that found desirable by actual experience in health center construction under this program.

The conference passed a resolution stating that when health centers are built under separate political jurisdictions, but in close proximity, the local political jurisdictions involved should plan the facilities so that in event of future consolidation both facilities can be utilized.

2. *Laboratory Examination for Rabies*

The conference recommended that specimens for laboratory examination for rabies should be forwarded to the State Laboratory only with the approval of the local health officer, and that the State Laboratory develop suitable dry-ice containers for shipping these specimens.

3. Test for Bacteriological Sterility of Infant Formulas

The conference approved a simplified laboratory procedure for testing the bacteriologic sterility of infant formulas prepared by the required terminal heat method.

4. Rh Testing in Public Health Laboratories

The conference approved a statement supporting the value of Rh testing, but left the advisability as to whether the tests should be done routinely in the local public health laboratory to local decision.

5. Sanitation at Camps for Children

The conference recommended to the State Department of Public Health that arrangements be made with the State Department of Social Welfare so that prior to their issuing a license to operate a camp for children, approval for the sanitation requirements be obtained from the local health department in whose jurisdiction the camp lies, or from the State Department of Public Health, through the part-time health officer, in those areas where there is no organized local health department.

In addition, several other matters were discussed by the conference as a whole and referred to committees for further study. Some of these include:

(1) Educational programs for training of public health nurses. The conference was particularly impressed with the new basic collegiate nursing program at UCLA.
(2) The relationship of local health departments to regional water pollution control boards.
(3) The use of the Professional Examination Service of the A.P.H.A. by local health departments.
(4) The use of mechanical milk dispensing devices.
(5) The determination of health needs for children of school age.
(6) Mechanical insecticide vaporizers.

Public Health in Mental Hospitals Discussed at Stockton Meeting

On May 20th and 21st the Third Annual Conference on Public Health in Mental Hospitals was held at the Stockton State Hospital, under the joint sponsorship of the California State Departments of Mental Hygiene and of Public Health. The problems under discussion were fly control, food handling, the improvement of laboratory services, and immunization against communicable diseases—subjects which had been suggested by the Department of Mental Hygiene.

These meetings have developed from the recognition that each mental hospital is in effect a community and, like any other community, each hospital has public health problems to meet and solve. Every hospital has to be concerned about water supply, sewage disposal, and environmental sanitation in general; and every hospital, by reason of the nature of its population, has particular reason to be concerned about the control of communicable diseases. In these annual meetings, personnel of the State Department of Public Health have an opportunity to share their special knowledge with those officers of mental hospitals who have been assigned public health responsibilities in the hospital community, and out of these meetings there has been established a permanent interdepartmental committee on public health in mental hospitals.

Immunization

Perhaps the most concrete result of the 1952 conference was the development of a standard immunization schedule, applicable to children and adults, establishing recommended procedures for immunization of the hospital population against smallpox, diphtheria, tetanus, and typhoid.

Laboratory Services

In the area of laboratory procedures, the decision was made that the Division of Laboratories of the State Department of Public Health would, during the ensuing year, visit each hospital and offer the same type of evaluation and consultation services which are routinely available to local health departments. The content of these visits will serve as the basis for a discussion of the subject at the next working conference.

Fly Control

The section on fly control discussed in detail the problems associated with this activity, and the various methods by which institutions might successfully combat these pests. It was agreed that measures directed toward the prevention of breeding were more effective than those directed against the adult fly itself; and at the same time it was pointed out that no single method is appropriate to all situations. Regardless of the multiplicity of new insecticides, mechanical barriers still play an important part.

Food Handling

The section on food handling concerned itself largely with plans for educational activities, with emphasis on in-service training of food handling personnel.

San Mateo Civil Service

San Mateo County has vacancies for a *physiotherapist* to work in the San Mateo Community Hospital, for a *clinical laboratory technician* to work in the new San Mateo Tuberculosis Sanatorium, and a *dietitian* to work at the community hospital. Salary ranges for these classifications are the same—$297 to $371. Interested persons should apply to the San Mateo County Civil Service Commission, Courthouse, Redwood City.

Border Public Health Association Annual Meeting Resolutions

At the tenth annual meeting of the United States-Mexico Border Public Health Association held recently at Monterey, Mexico, several matters of general interest were considered. The association passed resolutions that the Pan American Sanitary Bureau and the governmental agencies of the United States and Mexico take action upon the public health matters mentioned below. They recommended:

Tapeworm Infestation Control—That an educational program be launched for the control of pork tapeworm infestation which is an important public health problem in Mexico; that a parasitologic survey be conducted on a sampling basis of both the human and porcine population of Mexico; and that provisions for the detection in slaughterhouses of tapeworm in swine carcasses be vigorously executed.

Milk Pasteurization—That an educational program be developed to encourage proper pasteurization of all milk consumed in urban areas, with emphasis on the responsibility of the milk producers in carrying out the principles and practices endorsed by the Mexican Permanent Milk Commission and the National Association for Production of Pure Milk.

Rabies Control—That an investigation be instituted on the epizootiology of the vampire bat since paralytic rabies transmitted by vampire bats constitutes a serious menace to public health and agriculture economy; and that epidemiological data concerning the disease continue to be collected and exchanged by both governments.

Migrant Labor Regulation—That since Mexican laborers going to the United States present an important public health problem meriting every possible attention as part of the good neighbor policy, both governments take every possible step to assure that the admissions are legal; that complete pre-employment examinations be given to applicants; that the workers be given adequate housing, potable water, proper sanitary and recreational facilities, and adequate nutrition; and that the best possible health conditions be maintained in the areas where agricultural workers are assigned.

Yellow Fever Control—That measures for the complete eradication of the *Aedes aegypti* mosquito be intensified in order to remove the potential threat of urban yellow fever; that the vaccination program for immunizing all persons living in or visiting jungle areas be amplified; and the scientific investigation of various aspects of jungle yellow fever be given increased support and facilities.

State Public Health Assistance Funds Allocated for 1952-53

The Division of Local Health Service, State Department of Public Health, has notified the governing bodies of California cities and counties of the amount of state public health assistance funds which will be available in the 1952-53 Fiscal Year for the support of the local health department within their jurisdiction.

The 51 organized local health departments in the State will be allocated a total of $2,871,899. Additional funds in the form of federal grants-in-aid are also expected to be available. These funds usually approximate 20 percent of the state assistance funds.

Sixteen California counties have as yet no organized health department. The Division of Local Health Service has notified the board of supervisors in these counties that the following amounts of state funds would be available to them if a full-time county health department were established which met minimum standards and served all the cities in the county:

County	*State funds*
Alpine County	$199
Amador County	7,529
Calaveras County	8,146
El Dorado County	13,334
Glenn County	12,710
Lake County	9,446
Lassen County	15,199
Modoc County	7,963
Mono County	1,740
Nevada County	16,363
Shasta County	24,110
Sierra County	1,983
Siskiyou County	22,845
Tehama County	15,859
Trinity County	4,185
Tuolumne County	10,353

P.H.N. Vacancy, Alameda City

The Alameda City Health Department has a vacancy for a staff public health nurse. The salary range is $312 to $374 on a five-step plan. Car is provided. Further information may be secured from David Frost, M.D., Health Officer, 2226 Santa Clara Ave., Alameda.

San Diego Nursing Positions

There are openings in the San Diego County Health Department for seven staff public health nurses and one supervisor. The salary ranges are as follows:

Public health nurse—$296 to $360.

Supervising nurse—$343 to $417.

For additional information address J. B. Askew, M.D., Health Officer, San Diego County, Room 0170, Civic Center, San Diego 1, California.

Dr. Kulstad Resign as Dental Chief; Dr. Richards Appointed

Dr. Hugo M. Kulstad, Chief of the Division of Dental Health, has resigned, effective June 30th, after four years with the State Department of Public Health. Dr. Lloyd Richards, who joined the division last September, has been appointed as the new chief.

Dr. Kulstad, nationally known authority on public health dentistry, was appointed to direct the department's dental health program on July 1, 1948, when a Bureau of Dental Health was established. The bureau was given division status through legislative action in 1949. Dr. Kulstad had previously practiced dentistry in Los Angeles and Pomona since 1930. He is active in a number of state and national dental organizations, and has served as President of the American Society of Dentistry for Children.

Dr. Richards came to the department after two years as Supervisor of Dental Services with the Oakland Public Schools. He obtained his M.P.H. degree from the University of California School of Public Health in 1949. Dr. Richards saw four years of service in the Army Dental Corps, including a tour of duty in the European theater. From 1937-1943 he was in private practice in Detroit and from 1934-1937 was with the Children's Fund of Michigan as a children's dentist. Dr. Richards got his A.B. degree from Albion College, Michigan, and obtained his dental degree from the University of Michigan.

Ten Cases, One Death Recorded in Diphtheria Outbreak

The incidence of diphtheria in California has been decreasing steadily since 1920, but a recent outbreak of 10 cases and one death in Alameda and Contra Costa Counties underscores the need for continuing adequate immunization programs. In this instance, close cooperation between the two county health departments, with prompt investigation and institution of necessary control measures, quickly lessened the threat of the situation.

Investigation, isolation and quarantine are continually needed and used, but active immunization is regarded by public health authorities as the only method that has been really effective in the prevention of diphtheria.

In the period from 1920-1924 there were 44,638 cases of diphtheria in California. The disease has decreased progressively so that in the period from 1945-1949 only 4,159 cases were recorded. But while the decline in cases was marked, there was evidence that the disease was still widespread. In the earlier period cited it was reported from 56 of the 58 counties in the State, and it was still reported from 52 counties in the later period. Since 1949 the decline in numbers has continued, and progress has been made steadily in decrease of the spread. In 1950 there were 268 cases reported from 34 counties. In 1951 only 160 cases were reported from 33 counties. In the four and one-half months from January 1 to May 15, 1952, only 74 cases in 17 counties were reported.

Concurrently with the decrease in cases and spread, a steadily increasing proportion of diphtheria cases in adults has been noted in California. Since 1949 almost half the cases have been in those over 19 years of age. So the problems involved in mass immunization of adults have been receiving increased attention and study during recent years.

IV. Review of Reported Communicable Disease Morbidity—May, 1952

Diseases With Incidence Exceeding the Five-Year Median

Diseases	*May, 1952*	*May, 1951*	*May, 1950*	*5-year median*
Amebiasis	45	43	20	29
German measles	1,708	1,059	374	604
Hepatitis, infectious	50	12	30	13
Influenza	98	80	27	46
Measles	9,986	19,136	3,597	6,371
Meningitis (meningococcic)	36	26	19	20
Pertussis	405	323	1,145	347
Poliomyelitis	80	61	91	69
Rabies (animal)	29	6	16	16
Salmonella infections	45	17	114	17
Shigella infections	70	39	40	39
Streptococcal infections, respiratory, including scarlet fever	616	1,186	609	486

Diseases Below the Five-Year Median

Diseases	*May, 1952*	*May, 1951*	*May, 1950*	*5-year median*
Brucellosis	5	12	6	14
Chickenpox	5,550	6,331	4,959	5,650
Coccidioidomycosis disseminated	5	7	7	7
Diphtheria	17	18	19	29
Food poisoning	28	14	63	51
Mumps	3,610	2,531	5,497	4,827
Tetanus	4	3	6	5
Typhoid fever	5	9	8	8

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